

Case Number:	CM14-0133107		
Date Assigned:	08/22/2014	Date of Injury:	12/16/2013
Decision Date:	10/23/2014	UR Denial Date:	08/12/2014
Priority:	Standard	Application Received:	08/20/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 25 year-old patient sustained an injury on 12/16/13 while employed by [REDACTED]. Request(s) under consideration include Occupational therapy for the right wrist, twice weekly for six weeks (quantity 12). Diagnoses include right wrist pain/ possible diffuse extensor tendinopathy. MRI of right wrist on 5/20/14 showed minimal negative ulnar variance. Report of 8/4/14 from the provider noted patient with right wrist pain and stiffness with occasional numbness, tingling, weakness, and popping. Exam showed bilateral upper extremities without swelling, atrophy; wrist/ elbow/ hand with full range of active motion; intact sensation to radial/ median/ and ulnar nerves and motor strength; nonspecific diffuse tenderness over dorsal extensor compartment and forearm/wrist; pain with resisted extensor tendons; tenderness over lateral epicondyle; positive elbow Tinel's with intact sensation in all digits; and no pain on wrist supination and pronation. Current medications include Ibuprofen, Naprosyn, and Phenergan. X-rays of right wrist on 8/4/14 showed normal, unremarkable findings. The request(s) for Occupational therapy for the right wrist, twice weekly for six weeks (quantity 12) was not medically necessary on 8/12/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Occupational therapy for the right wrist, twice weekly for six weeks (quantity 12): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist & Hand Chapter, Physical/Occupational Therapy

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98-99.

Decision rationale: This 25 year-old patient sustained an injury on 12/16/13 while employed by [REDACTED]. Request(s) under consideration include Occupational therapy for the right wrist, twice weekly for six weeks (quantity 12). Diagnoses include right wrist pain/ possible diffuse extensor tendinopathy. MRI of right wrist on 5/20/14 showed minimal negative ulnar variance. Report of 8/4/14 from the provider noted patient with right wrist pain and stiffness with occasional numbness, tingling, weakness, and popping. Exam showed bilateral upper extremities without swelling, atrophy; wrist/ elbow/ hand with full range of active motion; intact sensation to radial/ median/ and ulnar nerves and motor strength; nonspecific diffuse tenderness over dorsal extensor compartment and forearm/wrist; pain with resisted extensor tendons; tenderness over lateral epicondyle; positive elbow Tinel's with intact sensation in all digits; and no pain on wrist supination and pronation. Current medications include Ibuprofen, Naprosyn, and Phenergan. X-rays of right wrist on 8/4/14 showed normal, unremarkable findings. The request(s) for Occupational therapy for the right wrist, twice weekly for six weeks (quantity 12) was non-certified on 8/12/14. Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Occupational therapy for the right wrist, twice weekly for six weeks (quantity 12) is not medically necessary and appropriate.